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INMATE SUICIDES: LONGITUDINAL AND CROSS-SECTIONAL FEATURES IN THE NEW YORK CITY DEPARTMENT OF CORRECTION

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PREFACE

This brief analysis has been prepared for the New York City Department of Correction which, with the Health Services Administration, shares responsibility for the physical and mental health of those placed in its custody. In response to the client's request, we consider here the perennial problem of inmate suicides, with the primary intent of comparing the recent experiences with those of the past. In the course of developing the historical perspective, it was also hoped that incidence patterns would emerge which, in light of what is generally known about suicide etiology, prevention and treatment, as well as current conjectures about how the Department ought to proceed to curtail suicide rates, would have implications for Departmental policy.

FOREWORD

"All those who would enter this arena of research had better be prepared for the difficulties which await; and no ready cures should be expected. It is not administrative devices that will bring fewer suicides, but kindly ministration based on the tragedy of humanity in being imprisoned by irrational biology and psychology whose depths we have only just plumbed, and which in turn are nursed by prudery and squeamishness in acknowledging them as realities."*

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*George Simpson, in the editor's introduction to Ref. (1), November 1950.

SUMMARY

Although we attempt to describe the prison suicide problem in terms relevant to management's resolution of Departmental policy on this issue, there are two compelling reasons why this brief examination has been predominantly descriptive and not prescriptive. First, the claims to causal and preventive knowledge in this area of psychology and sociology are seriously wanting. There are reasonable hypotheses relating to suicide and numerous guidelines for crisis intervention, but no ready cures to the problem or adequate predictive instruments to spot the suicide prone. This and the fact that a statistically scant 40 inmate suicides have occurred during the past five years in the New York City Department of Correction's prisons do not make significant progress through analysis a realistic expectation. While being guarded, therefore, in our own inferences drawn from the available records of the period, we have been able to advance somewhat in clarifying the situation, in identifying and dispelling some of the myths being promogated, and in providing data with which to contest or support the numerous conjectures and proposals lately served up. This should assist the Department in avoiding policies on which the data cast reasonable doubt. Clearly, many of these policies would entail substantial economic costs to the Department; they would also impose social costs on the majority of nonsuicidal inmates who would be directly or indirectly affected by the suicide measures undertaken.

A review of the reported suicide incidents of the past 4 3/4 years (1967 through September, 1971) and the institutional inmate flows indicates that on the basis of total new admissions, the ARS and Brooklyn experienced significantly higher suicide rates than the other five detention facilities (19 and 14 suicides per 100,000 new admissions, respectively). Though such rates attempt to account for the disparate capacities and populations of these institutions, they obviously fail to reconcile the differences in length of imprisonment or exposure amongst the various

facilities; the rates are especially deceiving when comparisons with the City-wide rates are drawn. Thus, when the rates are computed on the basis of numbers of suicides per 100,000 average daily census, the Manhattan House of Detention attains the largest rate (181) with the ARS (152) and Brooklyn (143) next in rank. The rate computed this way averages about 16 times higher than on the basis of new admissions. Without any further standardization for other inhomogeneities besides unit of population and exposure time over identical periods, we also find that the total prison rate is around 14 times that of the City.

The marked departure of prison suicide rates from those of the City is a phenomenon which has been sustained over the years 1967 to 1971. The spread is large enough that underreporting in the City and possible discrepancies in reporting in the prisons are not apt to account for the wide disparities. Both the City and prison rates have varied substantially over the period. The customary measure of this volatility, the standard deviation, is computed to be about 1/3 of the mean rate for the City, whereas it is nearly 1/2 of the average for the prisons. While this year's prison rate continues the upward trend begun in 1968, the rate for the first 3/4 of 1971 is within 20% of the average rate for the entire 4 3/4 year period and 25% below the peak established in 1967.

Just as institutional suicide differences may be important in establishing program priorities, so also inmate groups whose suicide experience significantly surpasses their proportionate representation in the population. In the context of hypotheses raised both internally and outside the Department of Correction about fruitful interventions and appropriate target groups, we find that the widely held notion that prison suicides are attributable to the large number of adolescents in the system is not supported by the historical evidence. The percentage of suicides in the 16-to-20-year-old adolescent group is low in comparison with their portion of the total detention population (including female sentenced individuals and sentenced help at the detention centers). By

contrast, we discover the opposite phenomenon in the 21-to-25 and 41-or-over groups, the latter being consistent with the pattern of suicide by age outside the prison setting. These differences, moreover, do not appear adventitious; they are statistically significant at a 99.5% confidence level.

Another popular statement is that the higher incidence of drug use amongst inmate admissions is the cause of the growth in suicides. The evidence for this, however, is inconclusive. On the basis of inmates' declarations of drug use upon admission, over half of the suicides were found to be drug users, significantly higher than estimated percentage population who declare themselves users. Yet, when we admit broader evidence of usage (arrest charge, medical exam, autopsy, subsequent admission of use, withdrawal, etc.), we find the conflicting result: drug-related suicides increase another 5%, while the population estimates more than double, making no significant difference between the observed drug suicides and the number expected on the basis of the increased population estimates.

Another hypothesis, offered by an experienced Department warden, is that placement of inmates in dormitory settings would eliminate suicides. Though this too proves inconclusive, the data do provide some clues that such facilities may curtail suicides. By contrast, the data reveal that a larger percentage of suicides occur in the "special, intensive observation areas" than in the general cell sections of the institutions. Because of the relatively small populations in these special observation cell blocks, the disparity in suicide rates is even more pronounced, on the order of 23:1. This suggests that the use of more correctional officers to thwart determined suicides is essentially futile (and may even aggravate the problem), while such approaches would be very costly indeed.

Apart from aspects of suicide related to hypotheses raised by others, there are a number of additional findings which may also bear on policy questions. Quite striking, for example, is the fact that as many of 8% of the suicides occur before completion of the first

day and 62% by the tenth day of confinement, far greater than the proportions of the population estimated to have these lengths of stay. This obviously critical time of adjustment for first-time offenders and recidivists alike raises the question of whether special service and treatment programs might be warranted for inmates during their early stages of imprisonment. Similarly, inspection of the inmate's stage of adjudication indicates that 54% of the suicide cases were in pre-trial and imprisoned fewer than 11 days, while nearly 70% were in this stage and in detention fewer than 2 months. This too raises speculation on the possibility of reducing suicides by creating a special holding procedure for these groups.

Other temporal patterns, apart from the heavy suicide incidence expected and observed during the night-time lock-in hours, revealed no statistical significance (e.g., suicides by day-of-week, month, or season). More definitive, but less clear for practical purposes, is the finding that suicides by the "white," non-Puerto Rican ethnic category far outstrips its respective percentage of the inmate population. This is also true for Puerto Ricans, but the opposite holds for "blacks."

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LIST OF ABBREVIATIONS

INSTITUTIONS

BRX = Bronx House of Detention for Men

BRK = Brooklyn House of Detention for Men

BRQ = Branch Queens House of Detention for Men

WOM = House of Detention for Women / New York City Correctional Institution for Women

MAN = Manhattan House of Detention for Men

QNS = Queens House of Detention for Men

ARS = Adolescent Remand Shelter

SUICIDE LOCATIONS

S.O. DORM = Special Observation Dormitory

S.O. CELL = Special Observation Cell

P.S. CELL = Punitive Segregation Cell

REC. AREA = Recreation Area

CORR. = Corridor

RECVG. RM. = Receiving Room

OTHER

C.O. = Correctional Officer

D.C. = The New York City Department of Correction

H.S.A. = The New York City Health Services Administration

I. INTRODUCTION

The mounting incidence of inmate suicides in the New York City correctional system is a particularly disturbing feature of recent prison conditions. Holding as a fundamental value an abhorrence of suicide in our society, our concern is further heightened when we realize that 60 percent of the inmate suicides in the past five years involved trial inmates -- alleged offenders detained for adjudication, many separated from the free community but for relatively small cash bail amounts. When we couple these with suicides involving convicted individuals still being held in a detention facility, we find that jointly they account for 90 percent of the suicides during the period.

This, in turn, raises the question of what can be done to either eliminate or ease the problem of prison suicides. Unfortunately, the claims to causal and preventive knowledge in this area of psychology and sociology are all too few. One thesis[1] states that suicide is not explicable from its individual forms, but that the totality of suicides in a society is relatable to certain societal characteristics. These social concomitants of suicide enable any individual suicide to be placed in its proper etiological category.* Another hypothesis[2] is that suicidal behavior is a combination of socially precipitating factors and psycho-instinctual impulses.**

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*Three categories of suicide are developed in Ref. (1): the "Egoistic" suicide which results from the lack of the individual's integration in society; the "Altruistic" suicide which derives from allegiance to higher commandments (e.g., political sacrifice, unthinking political loyalty); and the "Anomic" suicide which results from the individual's lack of regulation by society, or the sudden upset of his accustomed regulation (e.g., the sudden contraction of freedom experienced by the newly incarcerated, or the sudden expansion of freedom by the inmate released from custody).

**Again, three suicidal types are formulated in Ref. (2) based on the premise that the potential for suicide depends on early childhood experiences during the process of differentiation from the mother: the "Dependent-Dissatisfied" type who is easily identified as an irritatingly demanding, needful and egocentric person; the "Satisfied-Symbiotic" who is difficult to detect as a pseudo-normal individual who is suicidal only when there is a threat to a deeply entrenched, usually highly obscured dependency relationship; and the "Unaccepting" suicidal type, a pseudo-independent who is extremely willful and energetic, has a strong drive to succeed and is greatly resistive to help, keeping a rigid emotional distance between himself and others.

The point to be stressed is that there are reasonably hypotheses relating to suicide and guidelines for crisis intervention, but no ready cures or adequate predictive instruments. This and the fact that statistically a scant 40 inmate suicides have occurred during the past five years in the City's prisons do not make significant progress on this problem a realistic expectation. While being guarded in our own inferences drawn from the available records, we can help, nevertheless, to clarify the situation, dispel some of the myths being bandied about, and provide data to contest or support the numerous conjectures and proposals lately served up. This should assist the Department in avoiding policies on which the data cast reasonable doubt -- policies which may entail substantial economic costs to the Department (especially manning options) and social costs to the majority of nonsuicidal inmates who may be directly or indirectly (e.g., opportunity costs) affected by the suicide measures.

II. HISTORICAL SUICIDE INCIDENTS AND INSTITUTIONAL INMATE FLOWS

In this and the succeeding sections we develop longitudinal (over time) and cross-sectional (over population at given point in time) profiles of past suicides in an attempt to identify trends and detect patterns which may suggest fruitful courses for preventive action. The information is drawn from reported data, including the original institutional reports of "Unusual Occurrences"* as well as the Department's final official documentation of the background investigation and autopsy results. Other data, such as new admission statistics and average daily census, are derived from the Department's annual surveys. Personal attributes of the general inmate cohort (e.g., sex, age, ethnicity, etc.) are taken from sample data collected by the Institute during November 1969 and summarized in Ref. (3).** It should be understood therefore that these data are but estimates of the proportions of the entire inmate population having the specific characteristics. It should also be recognized that these estimates may not only suffer from sampling errors on the particular date of collection (e.g., non-exhaustive sample, observational mistakes, incorrect record entries, unconscious bias, etc.), but from non-representativeness with respect to other periods (i.e., population parameters may be changing over time). Finally, we note that although it is traditional to annualize the suicide data, this is an artificial framework which, in view of the statistically small number of instances, does not aid our present purpose. For convenience, we include most of

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*These incident reports are filed on the New York City Department of Correction's forms 26-A(4-63), 168(5-67)5C, 168(4-69), 26A(11-665M, and 168(6-65). A typical report of "Unusual Occurrences" is presented in Appendix B (with deleted inmate names, inmate numbers and institutional identification).

**Actually, two random samples were taken: a 10% sample at the ARS (i.e., 300 inmates) on September, 1969 and another 10% sample of the ARS on November, 1969 (for comparative purposes). Ten percent samples were also taken at the Branch Queens House of Detention for Men, the NYC Correctional Institution for Men, and the Women's House of Detention, 5% samples being taken at all other facilities (effects of reduction from 10% to 5% were tested and found in most cases to be insignificant at a 95% confidence level). Thus, the population parameter estimates are derived from a total of about 900 inmates (out of an average daily census in 1969 of 13,170).

these disaggregated observations (by year and/or institution) in Appendix A. As the appendices indicate, many of the "general patterns" exhibited and discussed in the main sections are imperfect when looked at by individual institution or year.

One widely held notion is that the Manhattan House of Detention for Men (more familiarly, the "Tombs") and the Adolescent Remand Shelter (ARS) are the worst institutions with respect to suicides. In Table 1 we see that Manhattan and the ARS are indeed highest in their numbers of suicides over the last 4 3/4 years.* By contrast, the Women's House is conspicuous by its absence of suicides for the entire period. Since the housing capacities and consequent inmate populations of these individual institutions are so disparate in size, however, this view of the problem (i.e., regarding suicide volume alone) is clearly biased. Better perspective can be gained by accounting for their obvious census differences and by computing their respective suicide rates, that is, the number of suicides per unit population during a fixed period.

In Table 2 (and Tables A-3 and A-5) we display the suicide rate based on both the total number of new admissions (column 1) and on the average daily census (column 2) at each institution during the period.** The unit of population taken is 100,000 inmates in both computations. We note that while Manhattan and ARS ranked first and second in number of suicides, they don't retain their ranking when the size of their new admissions cohorts are accounted for -- the ARS and Brooklyn House of

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*As evidenced in Table A-1 of Appendix A, this relationship does not hold for all the years of the period. We also note that the distribution of suicides by institution is significantly different (at 99.9% confidence level) from that based on equal likelihood and number of years in operation. It is also significantly different (at 99% confidence level) from that based on an equal likelihood assumption, weighted for both the number of years in operation and the proportions of total housing capacity. Here, as throughout the report, the statistical test referred to is the "Chi Square" test.

**Total admissions, average daily census, and average length of imprisonment data are detailed in Tables A-2, A-4 and A-6, respectively, of Appendix A.

Table 1

SUICIDES BY DETENTION INSTITUTION

Institution	Total No. Suicides*
Bronx	1
Brooklyn	9
Br. Queens	1
Women's House	0
Manhattan	13
Queens	2
Adol. Remand Shelter	11
TOTAL	37

*Total for the period January 1, 1967 to September 30, 1971.

Table 2

SUICIDE RATES

Institution	Average Rate		Standard Deviation
Bronx	3*	26**	
Brooklyn	14	143	
Br. Queens	7	60	
Women's House	0	0	
Manhattan	8	181	
Queens	9	47	
Adol. Remand Shelter	19	152	
TOTAL	7	112	52
New York City***		8	2.5

*Suicides per 100,000 total new inmate admissions: 1967-1971 (1st 9 months).

**Suicides per 100,000 average daily census: 1967-1971 (1st 9 months).

***See Ref. (4).

Detention are highest. The rates based on total new admissions are found to be significantly different (at a 99.9% confidence level) from the distribution expected on the hypothesis that suicides are apportioned according to the institution's percentage of total admissions for the period, thereby making all the institutional rates equal. In fact, on this basis we would have expected Manhattan to be highest (with about 15 suicides expected) and Branch Queens to be lowest (with about 1 suicide predicted), rather than the Women's House. Under this hypothesis, we would have also anticipated about 4 or 5 suicides at the Women's House, instead of the 0 actually observed, with the balance of expected male suicides being about 33 or 32. In turn, this would have made the male and female suicide rates nearly equal (about 9.3). These rates as well as those based on the actual experience differ appreciably from the approximate 3:1 male-to-female ratio of suicide rates observed in society generally.

Even this view of the problem is deceiving when either comparisons with other institutions and especially with the City-wide rates or other jurisdictions are to be drawn.* Suicide rates calculated on the basis of total new admissions fails to reconcile the fact that the exposure or average length of stay in the institutions is generally different and that overall, the average length of stay in detention is 33 days, rather than essentially the whole year as in the City.** Thus, the suicide rates displayed on the second column of Table 2 give a truer picture of the grimness of the suicide problem in relation to the City, from which most of the inmates come. The rates computed this way average 16 times higher than on the basis of total admissions (column 1, Table 2). Without any further standardization for other inhomogeneities besides unit of population and exposure time over identical periods, we also note that the total prison rate is around 14 times that of the City. The differences in rates amongst the detention facilities themselves do not appear adventitious; they are significantly different (at a 99.9% confidence level) from those attributable to the respective proportions of average daily census at each institution.***

The marked departure of prison suicide rates from those of the City

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*See Table A-20 for prison suicide data in other major cities.

**A summary of the various average lengths of stay by institution and year is given in Table A-6 of Appendix A.

***This is equivalent to hypothesizing that each institutional rate [illegible] and equal to the average overall rate for the period.

is a phenomenon which is sustained over all the years of the period 1967 to 1971 as evidenced in Figure (1). The spread is large enough that underreporting in the City and possible discrepancies in reporting in the prison (i.e., either overreporting by falsely attributing deaths to suicides, or underreporting by failing to recognize a death as a prisoner suicide) are not apt to account for the wide disparities.* As the figure also illustrates, both the City and prison rates have varied widely over the period. The customary measure of dispersion, the standard deviation, is computed to be about 31% of the mean rate for New York City, whereas we find the value of 46% for the prisons. While this year's prison rate continues the upward trend begun in 1968, it is not clear that the outcome for all of 1971 will surpass the suicide rate of 176 (suicides per 100,000 average daily inmate census) established in 1967. The present rate (i.e., first 9 months of 1971) is within 20% of the average rate for the 4 3/4 period and 25% below the peak of 1967. Of course, if the assumption is made that the 9 month trend will continue linearly, then the 1971 experience will match the last 1967 peak.

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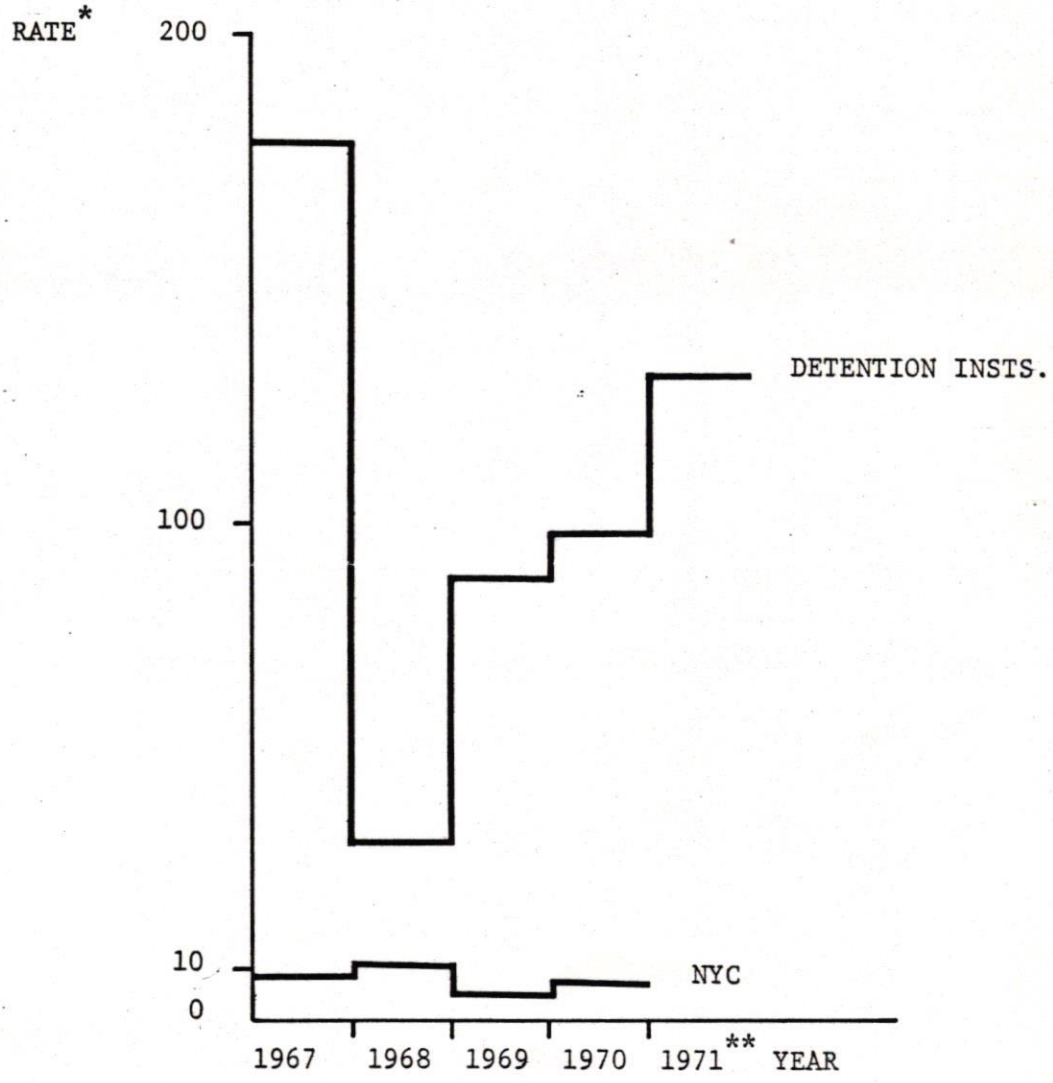
*There are several disincentives to full reporting of suicides in the community. The most obvious ones stem from life insurance policies having suicide contestability periods and from the social stigma attached to suicide with its concommitant influence on reporting practices. (Government statistics indicate that over 20,000 suicides occur annually; Ref. (5) states that the actual volume may be more like 25,000. As Ref. (6) also points out, suicide is about the 10th leading cause of death in the United States; 4th amongst those aged 20 to 45; 5th amongst children aged 15 to 19; and around 2nd or 3rd amongst college students and servicemen. From an insurance point of view, Ref. (6) also indicates that $61 million was disbursed by life insurance companies in 1961 to survivors of suicides.) In prison, the chief incentive to underreportage would appear to be the poor image, public pressures, and grand jury investigations which ensue and, for the responsible correction officer and warden, the implications of negligence or malfeasance.



*Suicides per 100,000 average daily census.

**First 9 months.

Fig. 1 -- Suicide rates during 1967-1971

III. CHARACTERISTICS OF INMATE SUICIDES

Just as institutional suicide differences may be important in establishing program priorities, so also inmate groups whose suicide experience significantly surpasses their proportionate representation of the total prisoner population. In this section, we identify some personal attributes of the inmate suicides which may suggest target groups for selectively applying preventative measures as well as "do nothing" groups. We will consider these populations in the context of hypotheses raised both internally and outside the Department of Correction about fruitful interventions. In the following section, we will also introduce some other correlates of prisoner suicide which may point the way for further inquiry and, ultimately, positive policy formulation.

In addition to the perceptions about suicide frequency by individual institution and year, there is also the widely held notion that this prison problem is attributable to the large number of adolescents in the system. This view, too, runs counter to the historical evidence. In Table 3 we note the low percentage of suicides in the 16-to-20-year-old adolescent group in comparison with their portion of the total detention population (including female sentence and sentenced help at the detention centers).* By contrast, we see the opposite phenomenon in the 21-to-25 and 41-or-over groups. The relatively higher suicide rate for the more elderly is consistent with the pattern of suicide by age outside the prison setting.

Another popular belief, expressed by the Department, HSA and the Mayor's Office, is that the higher incidence of drug use amongst inmate admissions is the cause of the growth in suicides. As Tables 4 and 5 show, the evidence for this is inconclusive. On the basis of the inmate's declaration of drug use upon admission (Table 4), we see that slightly over half the suicides were committed by drug users.** This is significantly

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*These differences in incidence by age group are statistically significant at a 99.5% confidence level.

**In regard to the term "drug user," we note that of the 37 suicides during the period, all but 2 were on heroin; one suicide had been using LSD, the other, an amphetamine.

Table 3

SUICIDES AND INMATE AGE

Age Group	% Total Suicides*	Est. % Population**
16-20	27	40
21-25	49	24
26-40	13	32
41+	11	4

*Percentage total suicides for the period 1967 through first 9 months of 1971. Actual counts by the same ascending age groups were 10, 18, 5, and 4 (see Table A-7).

**Estimates derived from survey described in Ref. (3).

Table 4

PERCENTAGE SUICIDES BY INMATE DRUG USE

	% Suicides	Est. % Population
Drug User*	54	24
Non-User	46	76

*Inmate's declaration upon admission (see text). Entries represent rounded percentages of total suicides or population (see Ref. (3)).

Table 5

PERCENTAGE SUICIDES BY INMATE DRUG USE

	% Suicides	Est. % Population
Drug User*	59	55
Non-User	41	45

*Additional drug evidence (see text). Entries represent rounded percentages of total suicides or population as in Table 4.

higher than the estimated percentage population who declare themselves addicts.* Yet, if we admit additional evidence of drug use, such as primary or secondary drug arrest charge, medical examination, autopsy, subsequent admission of drug use, withdrawal during incarceration, etc., we find the conflicting result summarized in Table 5. On the basis of this broader evidence we see that the drug-related suicides have increased 5%, while the population estimates have more than doubled. Since differences at least as large as these between actual and expected numbers of suicides by drug-use could have occurred with about a 60% chance in a random sample of suicides, we now find no significant relation between suicides and drugs.

A hypothesis offered by one of the Department's wardens is that dormitory settings would eliminate prison suicides. Though also still inconclusive, Table 6 provides some clue that such facilities may curtail suicides. An estimate of the dormitory cell population based on a 10% random sample of days in 1971 (uniformly distributed by month) indicates that 12% of the detention population were so housed during the period.** We do not know if this estimate is representative of the other periods in 1967-1971, and we do not know the selection process, care service differences or personal characteristics of those placed in dorms. Clearly, these or other factors may have been more influential in regard to absence of dormitory suicides during the 4 3/4 years than the dormitory setting per se. With these caveats in mind, and on the

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*These population estimates are based on the sample of Ref. (3) mentioned earlier. The differences are statistically significant at the 99.9% confidence level.

**As a partial check on the validity of the 10% dorm and special observation cell populations, the total institutional census was also collected. The error between the exact average daily census for the first 9 months of 1971 and that computed from the 10% random sample was less than 1% across all 7 facilities. Since the New York City Correctional Institution for Women replaced the House of Detention for Women on June 16, 1971, only 17 sample points were taken at the Women's House. Similarly, since the dormitories were closed between June 21 and October 13, 1971 at the Brooklyn House of Detention for Men, only 17 sample points were taken there for the dorm estimate; the other computations involved the full 9 months.

Table 6

SUICIDES BY LOCATION WITHIN INSTITUTIONS

	% Suicides	Est. % Population*
General Cells	43	86
Dormitories	0	12
Special Observation Cells	46	4
Other Areas**	11	--

*Based on a 10% random sample for each month of 1971 (see text).

**One suicide (3% of the total) occurred in the ARS kitchen; 3 (or 8% of the total) occurred in the ARS infirmary.

assumption that the number of suicides in dorm, special observation, and general housing areas reflects only the portions of population actually residing in these areas, we would have expected around 4 suicides in dorms, 1 in the special observation sections and 28 in the general cell blocks. Accordingly, we find the differences between these expected locational counts and the observed ones to be statistically significant at the 99.9% confidence level.*

An unfortunate revelation of the other locational data shown in Table 6 is that a larger percentage of suicides occur in the special, intensive observation areas than in the general cell sections of the institutions. Since the population in the special observation areas (including the administrative segregation cells) is but 4% of the total census on average, while in the general areas it is 86%, the disparity in suicide rates is even more pronounced -- on the order of 23:1. This suggests that the use of correctional officers in thwarting those determined to commit suicide could be very costly indeed, requiring perhaps more than one officer per suicidal inmate. Given the performance to date and the $70,000 annual cost per round-the-clock housing post, other alternatives should be sought.** Rejects 1-1 suicide watch.

Having discussed aspects of suicides which relate to hypotheses raised by others, we turn now to several additional findings which may also bear on policy questions. Looking at Table 7 which summarizes length of imprisonment till suicide, we find quite striking the fact that as many as 8% of the suicides occur before completion of the first day and 62% by the 10th day. As we also see, this is far greater than the proportion of the population having these lengths of stay as estimated

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*This is also true if the dichotomous categories of dorm and all-other or special observation and all-other are tested.

**Of course, it can be argued as well that the suicides in special observation cells would have been even higher but for the effectively larger number of officers in these areas. Likewise, it can be hypothesized that more intensive observation either precipitates suicide or encourages self-inflicted injury which unintentionally results in death (i.e., because the acting-out inmate may be given a false sense of security in the intensive observation units). - Good points, but overlooks fact that suicidal inmates recognized as such are placed in special SU areas + removed from Gen pop. This accounts for high rate - i.e. nature of the population.

Table 7

PERCENTAGE SUICIDES AND LENGTH OF IMPRISONMENT

Days Since Admission	% Total Suicides	Est. % Population*
0-1	8	--
0-10	62	20
11-91	28	44
92+	10	36

*Derived from Ref. (3) sample (see text).

from a random sample taken on a randomly selected day (Ref. (3)). This is obviously a critical time of adjustment for first-time offenders and even recidivists (since the physical circumstances may be the same, but the inmate cohort is very likely to be different). Accordingly, special treatment programs may be warranted for inmates during their early stages of (re)incarceration -- perhaps placement of new admissions in a reception center with higher levels of counseling and other services.

Closely related to the inmate's elapsed time in prison is his stage of adjudication. From Table 8 we are not surprised to learn that a high percentage of suicides are only in the pre-trial stage of court process. Actually, 54% of the suicide cases were pre-trial and imprisoned fewer than 11 days. Nearly 70% were in this stage and in detention less than 2 months. This too raises speculation on the possibility of reducing suicides by creating a special holding procedure for these groups.

If we inspect suicide incidents by their tour of occurrence (Table 9), the heavy incidence during the lock-in hours (approximately 9 P.M. to 6 A.M.) is as expected. In the absence of the special observation suicide data described earlier, this might suggest, as has been done, heavier manning and observation during these hours -- a weighty policy issue in view of the budgetary implications. Other temporal patterns, such as suicide by day-of-week, month, or season were found to be of no statistical significance (see Appendix A).

- what about weekends + holidays?

In the realm of noteworthy, but unclear as to usefulness, is this final table of the proportion of inmate suicides falling into the 3 ethnic classifications indicated. Here we observe that the percentage of suicides by the "White," non-Puerto Rican category far outstrips the respective percentage population estimate. This is also true for Puerto Ricans, but the opposite holds for "Blacks." The City-wide suicide experience for these groups is capsulized in Table A-21 of Appendix A.

Table 8

PERCENTAGE SUICIDES AND STAGE OF ADJUDICATION

Court Status	% Total Suicides	Est. % Population*
Pre-Trial	68	40
Trial in Criminal Court	0	2
Convicted and Waiting Sentence by Criminal Court	0	1
Indictment by Grand Jury	16	27
Trial in Supreme Court	3	13
Convicted and Waiting Sentence by Supreme Court	5	7
Sentenced and Awaiting Transfer	8	10

*Derived from sample of Ref. (3) (see text).

Table 9

PERCENTAGE SUICIDES BY TOUR OF OCCURRENCE

Tour	% Total Suicides
Midnight - 8 AM	35
8 AM - 4 PM	14
4 PM - Midnight	51

Table 10

PERCENTAGE SUICIDES AND ETHNICITY

	% Total Suicides	Est. % Population*
White	41	18
Black	16	64
Puerto Rican	43	18

*Derived from Ref. (3) (see text).

IV. CONCLUSION

The absence of a comprehensive, consistent and systematic hypothesis of suicide causality prevents enlightened resolution and confident management action on this perennial prison problem. This, though the dominant obstacle, is not the only factor which inhibits permanent solution. The brevity, scope and depth of this examination, the statistically scant 40 inmate suicides of the past 5 years, inadequate reportage, and the lack of adequate diagnostics to spot the suicide prone have also forced this analysis to be predominantly descriptive rather than prescriptive. Coupled with conflicting operational goals, it is a priori evident that significant immediate progress through this essentially actuarial approach or others is an unrealistic expectation.*

Nevertheless, a few patterns and clues have emerged from the available records of 1967 to 1971 which have enabled us to advance somewhat in clarifying the situation in and amongst the Department's institutions. We have also succeeded in identifying and dispelling some of the myths being bandied about and in providing data with which to contest or support, if not conclusively, the numerous conjectures and proposals lately served up to the Department of Correction's administrators. This should assist the Department in avoiding policies on which the data cast reasonable doubt and, in turn, preserve their limited resources for more pressing priorities and more rigorously defended programs.

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* One of the most obvious conflicts arises from the custodial requirement that an officer must be in the company of another before he can enter an inmate's cell during nighttime lock-in (see Ref. (8)); this and the poor internal prison communication system hamper a speedy response to a suicide attempt. Another conflict derives from the opportunity costs to the Department in pursuing suicide measures and from the social costs imposed on the majority of nonsuicidal inmates who would be directly or indirectly affected by undertaken suicide programs.

Appendix A

SUICIDE DATA DISAGGREGATED BY INSTITUTION AND YEAR

Table A-1

SUICIDES BY DETENTION INSTITUTION
1967-1971

Institution	Year					Total
	1967	1968	1969	1970	1971	1967-1971
BRX	0(0)	0(0)	0(0)	0(0)	1(14)	1(3)
BRK	3(33)	2(3)	1(1)	2(25)	1(14)	9(24)
BRQ	1(11)	0(0)	0(0)	0(0)	0(0)	1(3)
WOM	0(0)	0(0)	0(0)	0(0)	0(0)	0(0)
MAN	5(56)	0(0)	2(6)	3(38)	3(14)	13(35)
QNS	0(0)	1(20)	1(4)	0(0)	0(0)	2(5)
ARS***	-	0(0)	4(2)	3(38)	4(57)	11(30)
TOTAL	9(24)**	3(8)	8(22)	8(22)	9(24)	37(100)

*The first entry is the number of incidents for the institution and year; the number in parentheses indicate the rounded percentage of total suicides for the year.

**Here the number in parentheses is the rounded percentage of total suicides for all 5 years.

***Figures include the infirmary, which receives both adolescent and adult patients. The ARS operation began October 14, 1968, before which the adolescents were housed at the Brooklyn House of Detention for Men.

Table A-2

TOTAL INMATE ADMISSIONS*
1967-1971

Institution	Year					
	1967	1968	1969	1970	1971**	1967-1971
BRX	5933	5080	6073	8619	7831	33536
BRK	14453	16219	8939	11952	12471	64034
BRQ	8485	4814	27	65	5	13396
WOM	9508	9611	11512	10060	7513	48204
MAN	28184	33726	44264	34059	16404	156637
QNS	3791	4261	3954	5574	3590	21170
ARS***	-	4522	18252	18169	15614	56557
TOTAL	70354	78233	93021	88498	63428	393534

*Each entry represents the sum of direct admissions, transfers from New York State institutions, new admissions and new cases from court.

**First 9 months.

***Figures include the infirmary. The ARS operation began October 14, 1968.

Table A-3

SUICIDE RATES BASED ON TOTAL ADMISSIONS
BY DETENTION INSTITUTION
1967-1971

Institution	Year*					Total
	1967	1968	1969	1970	1971	1967-1971
BRX					13	3
BRK	21	12	11	17	8	14
BRQ	12					7
WOM						0
MAN	18		5	9	18	8
QNS		23	25			9
ARS			22	17	26	19
TOTAL	12.8	3.8	8.6	9.0	15.0	7
% Increase		-70	125	5	66	

*Entries are rounded suicide rates per 100,000 new inmate admissions (including recidivists), i.e., the number of suicides for the indicated institution and year divided by the respective total new admissions (per 100,000).

Table A-4

AVERAGE DAILY CENSUS BY INSTITUTION:
1967-1971

Institution	Year					Total
	1967	1968	1969	1970	1971**	1967-1971
BRX	780	793	938	1012	800	868
BRK	1207	1317	1471	1478	1358	1367
BRQ	349	339	294	223	151	278
WOM	387	371	527	592	531	479
MAN	1446	1642	1812	1735	1299	1602
QNS	934	895	911	897	597	860
ARS	-	2990*	3017	2332	2099	2552
TOTAL	5103	8082	8970	8269	6835	7484

*Opened 10/14/68 (79 days of operation in 1968).

**First 9 months (273 days in 1971).

Table A-5

SUICIDE RATE BASED ON
AVERAGE DAILY CENSUS BY INSTITUTION*
1967-1971

Institution	Year					Average**	Std. Deviation
	1967	1968	1969	1970	1971	1967-1971	
BRX					125	26	56
BRK	248	152	68	135	74	143	73
BRQ	287					60***	128
WOM						0	0
MAN	346		110	173	231	181	130
QNS		112	110			47	61
ARS	-		133	129	191	152	35
TOTAL	176	37	89	97	132	112	52
% Increase		-79	141	10	35		-
NYC Rate****	9.6	10.5	5.6	6.0	†	8	2.5
% Increase		9	-47	7	†		-

*Each entry is the suicide rate per 100,000 inmate days for the year and institution indicated. The rate is obtained by dividing the number of suicides for the institution and year by the corresponding average daily census and multiplying the result by 100,000.

**Average rate is based on the relevant number of years (i.e., 1971 counts as 3/4 year and 1968 at the ARS, for .22 year).

***Branch Queens not in full operation between October 5, 1970 and February 1, 1971.

****Source of reported suicides: Ref. (4).

† Data Unavailable.

Table A-6

AVERAGE LENGTH OF INMATE STAY*
1967-1971

Institution	Year					
	1967	1968	1969	1970	1971	1967-1971
BRX	48	57	56	43	28	45
BRK	30	30	60	45	30	37
BRQ**	-	-	-	-	-	-
WOM	15	14	17	21	19	17
MAN	19	18	15	19	22	18
QNS	90	77	84	59	45	70
ARS	-	52	60	47	37	49
TOTAL	28	25	34	33	29	33

*Each entry represents the mean length of inmate stay in days, as computed by multiplying the average daily census by the number of days that the institution was in operation for the year and dividing the result by the corresponding number of total new admissions.

**Since Branch Queens serves primarily to receive overflows from the other male detention institutions and since total admissions data fail to reflect this fact, the average length of stay cannot be obtained from the accompanying tables of average daily census and total admissions.

Table A-7

PERCENT TOTAL SUICIDES BY INMATE AGE

Age	% Pop.*	1967	1968	1969	1970	1971	Total (1967-1971)
16-20	39.6	33**	0	25	25	33	27
21-25	24.5	44	100	38	38	56	49
26-30	15.9	11	0	13	13	0	8
31-35	8.9	0	0	0	13	0	3
36-40	7.0	0	0	13	0	0	3
41+	4.1	11	0	13	13	11	11

*Population estimates based on 5% and 10% samples of 1969 inmate records as discussed in Ref. (3).

**Entries are rounded percentage total suicides across all ages for the period indicated in the column heading.

Table A-8

PERCENTAGE SUICIDES BY INMATE DRUG USE

	Year**					Total	Est. %
	1967	1968	1969	1970	1971	1967-1971	Population
Drug User*	78	33	50	38	56	54	23.9
Non-User	22	67	50	63	44	46	76.1

*Based on the inmate's declaration upon admission (see text).

**Entries represent the rounded percentage suicides associated with drug use for the year indicated.

***These are approximate population percentages derived from the 10% sample discussed in Ref. (3). The estimates are based on those declaring themselves addicts upon admission (DAT).

Table A-9

PERCENTAGE SUICIDES BY INMATE DRUG USE

	Year**					Total	Est. %
	1967	1968	1969	1970	1971	1967-1971	Population***
Drug User*	78	33	63	37	67	59	55.1
Non-User	22	67	37	63	33	41	44.9

*Based on the inmate's declaration upon admission or showing narcotics evidence as indicated by either a drug or drug-related charge, secondary drug charge, court ordered examination, autopsy, withdrawal in prison, or the result of background investigation.

**Entries represent the rounded percentage suicides associated with drug use for the year specified.

***These are approximate population percentages derived from the 10% sample discussed in Ref. (3). The estimates are based on those declaring themselves addicts upon admission (DAT) or showing narcotics evidence as indicated by either a primary or secondary drug or drug related arrest charge, a court ordered examination for addiction, or admission by the inmate of narcotics usage or addiction.

Table A-10

SUICIDE BY LOCATION WITHIN INSTITUTION

Location	Institution and Year ('67/68/69/70/71)*							Total	(%)
	BRX	BRK	BRQ	WOM	MAN	QNS	ARS		
S.O. Dorm								0	(0)
S.O. Cell		10110	10000		30012	01000	00011	13	(35)
P.S. Cell		10000			00010		00101	4	(11)
Cell	00001	12011			20211	00100	00111	16	(43)
Dorm									
Corr.									
Rec. Area									
Outside									
Recvg. Rm.									
Clinic									
Kitchen							00100	1	(3)
Mail Rm.									
Visit Rm.									
Infirmary							00111	3	(8)
Misc.									

*Each institutional entry represents the sequences of total annual suicides in the order 1967, '68, '69, '70 and '71. Thus, under Brooklyn and Cells, the notation 12011 designates 1 suicide in 1967, 2 in 1968, zero in 1969, 1 in 1970, and 1 in the first 9 months of 1971.

Table A-11

PERCENTAGE SUICIDES BY LENGTH OF STAY

No. Days*	Year**					Total	% Pop.***
	1967	1968	1969	1970	1971	1967-1971	
0	11		25			8	20.1
1-10	67	67	38	63	44	54	
11-20	11		25	13	11	14	10.1
21-30					11	3	8.7
31-40	11			13		5	15.7
41-50						0	
51-60						0	
61-70		33			11	5	9.3
71-80						0	
81-90						0	
91-100					22	5	36.0
101+			13	13		5	

*This is the time from the date of admission to the institution in which the suicide occurred until the date of the suicide at the same institution.

**Table entries in each column represent the rounded percentage of suicides for the year with the indicated length of stay.

***These approximate population percentages are derived from the 10 percent 1969 sample discussed in Ref. (3).

Table A-12

PERCENTAGE SUICIDES BY COURT PROCEDURE†

	Year*					Total
	1967	1968	1969	1970	1971	1967-1971
Pre-trial				88	33	27
Trial in Criminal Court						0
Waiting Sentencing in Criminal Court		33	13			5
Indictment by Grand Jury					33	8
Trial in Supreme Court		33		13	11	8
Waiting Sentencing in Supreme Court	89	33	75		11	43
Sentenced**	11		13		11	8

*Each entry represents the rounded percentage suicides in the indicated stage of court process for the year.

**Awaiting transfer to sentence institution.

† It is also noteworthy that none of the suicides had no court appearances, that 68% had 1, and 32% had 2 or more.

Table A-13

PERCENTAGE SUICIDES BY INMATE ARREST CHARGE

Charge*	Year***						% Pop.**
	1967	1968	1969	1970	1971	1967-1971	
Other Misd. & Viol.						0	2.4
Petty Larceny	22				11	8	4.8
Grand Larceny			13		11	5	4.6
Poss. Hypo/Narc. Loiter	11					3	2.1
Poss. Drugs & Intent to Sell	22		25	13	11	16	14.7
Sale of Drugs				25		5	9.8
Criminal Trespass		33				3	2.4
Burglary	11	33	13		22	14	10.4
Crim. Poss. Stol. Prop.			13	13		5	5.4
Poss. Weapon						0	3.7
Other Felonies			13		11	5	3.0
Assault	11			13	11	8	5.6
Robbery			25	13	11	11	20.5
Mansltr./Crim. Neg. Hom.						0	2.1
Murder	11	33			11	8	3.6
Viol. Probation						0	0.6
Viol. Parole						0	3.1
Youth Offndr./Way. Minor						0	0.6
Prostitution						0	1.0
Sentenced to NACC	11.					3	-
Sentenced Help						0	-
Misc.				25		5	-

No sex offenses?

*This table also includes the non arrest charge categories sentenced help and sentenced to NACC.

**Approximate population percentages derived from the 10 percent 1969 sample discussed in Ref. (3).

***Entries for each year represent the rounded percentage suicides for the year having the arrest charge indicated.

Table A-14

SUICIDES BY TOUR AND INSTITUTION

Tour	Institution and Year ('67/68/69/70/71)*							Total	(%)
	BRX	BRK	BRQ	WOM	MAN	QNS	ARS		
MID-8		01010			10111		00412	13	35
8-4		11000			00011		00010	5	14
4-MID	00001	20111	10000		40111	01100	00012	19	51

*See Table A-10 for explanation of notation.

Table A-15

SUICIDES BY MONTH AND INSTITUTION

Month	Institution and Year ('67/68/69/70/71)*							Total	(%)
	BRX	BRK	BRQ	WOM	MAN	QNS	ARS		
JAN		00010			10001		00010	4	(11)
FEB		00001			10000		00001	3	(8)
MAR							00100	1	(3)
APRIL					00100	01100	00010	4	(11)
MAY								0	(0)
JUNE		20010			20000		00001	6	(16)
JULY	00001				00100		00001	3	(8)
AUG		00100			10000		00101	4	(11)
SEPT		10000			00001			2	(5)
OCT		01000	10000		00011		00010	5	(14)
NOV		01000			00020		00200	5	(14)
DEC								0	(0)

*See Table A-10 for explanation of notation.

Table A-16

SUICIDES BY DAY OF WEEK

Day	Institution and Year ('67/68/69/70/71)*							Total	(%)
	BRX	BRK	BRQ	WOM	MAN	QNS	ARS		
MON		10000						1	(3)
TUE		00100			10110	01000	00201	8	(22)
WED		10010			10000	00100		4	(11)
THUR		02001	10000		10001		00010	7	(19)
FRI	00001	10010			10021		00011	9	(24)
SAT					10000		00112	5	(14)
SUN					00101		00100	3	(8)

46% weekend!

*See Table A-10 for explanation of notation.

Table A-17

SUICIDES AND CELL OCCUPANCY

No. In Cell	1	2
No. Suicides*	24	12
% Total	67	33

*One suicide of the total 37 occurred in the messhall.

Table A-18

SUICIDES AND ETHNICITY

	1967	1968	1969	1970	1971	1967-1971	% Total*	% Pop.**	% NYC***
White	5	1	1	0	6	13	41	17.6	86
Non White	4	0	6	7	2	19	59	82.4	14
Black	2	0	1	1	1	5	16	63.9	-
Puerto Rican	2	0	5	6	1	14	43	18.5	-
Unknown	0	2	1	1	1	5	-	-	-

*Percentage total of known "racial" categories.

**Estimates based on the data of Ref. (3).

***Percentage of total New York City reported suicides by "white" and "nonwhite" categories during 1967 to 1970 as given in Ref. (4).

Table A-19

PERCENTAGE SUICIDES BY IMPLEMENT

Implement	Year*					Total
	1967	1968	1969	1970	1971	1967-1971
Towel					33	8
Mattress Ticking				13		3
Bed Sheet	56	33	38	38	33	41
Belt	11	33	50	13	11	22
Tie	11	33				5
Laces/Socks	11			25		8
Scarf				13		3
Shirt	11				22	8
Knife			13			3
All Other						0

*Entries are the rounded percentage of total suicides for the year in the indicated implement category.

Table A-20

SUICIDES IN SELECTED MAJOR U.S. CITY PRISON SYSTEMS*

City	No. Suicides 1971	1970	Approx. Census 1971
Atlanta (Fulton County)	0	2	822 (500 trial)
Baltimore	1	4	1295
Boston (Suffolk County)	0	?	300
Chicago (Cook County)	1	8	3500
Cincinnati (Hamilton County)	0	0	?
Cleveland (Cuyahoga County)	2	?	705 (415 trial)
Dallas (City & County)	0	?	225 + 1750
Detroit (Wayne County)	3	0	979
District of Columbia	0	?	1225
Houston (Harris County)	0	0	2237
Los Angeles	3	?	11000 (6800 trial)
Miami (Dade County)	1	?	525
Montgomery (Alabama)	0	0	100 (45 trial)
New Orleans	0	?	1204 (359 trial)
Philadelphia	1	?	2619
Pittsburgh (Allegheny County)	1	?	430 (200 trial)
St. Louis	0	0	580 (460 trial)
San Diego	1	0	1350 (675 trial)
San Francisco (City & County)	0	0	754
Seattle (City & County)	1	0	730 (400 trial)

*Suicide data and daily census (sentenced plus detention) estimates from Ref. (7).

Table A-21

NYC REPORTED SUICIDES BY ETHNICITY AND SEX: 1967-1970*

	1967				1968				1969				1970			
	W(%)	NW	W/NW	RATE	W(%)	NW	W/NW	RATE	W(%)	NW	W/NW	RATE	W(%)	NW	W/NW	RATE
MALE	428(85)	75	5.7		460(83)	92	5.0		263(89)	32	8.2		277(87)	42	6.6	
FEMALE	244(88)	33	7.4		255(85)	46	5.5		138(86)	22	6.3		133(88)	19	7.0	
TOTAL	672(86)	108	6.2	9.6	715(84)	138	5.2	10.5	401(88)	54	7.4	5.6	410(87)	61	6.7	6.0
% MALE	64	69			64	67			66	59			68	69		
% FEMALE	36	31			36	33			34	41			32	31		
MALE/FEMALE	1.8	2.3			1.8	2.0			1.9	1.5			2.1	2.2		

*Data are derived from Ref. (4); notation is as follows: W = White, NW = None-White, W/NW = White divided by Non-White, RATE = Number of suicides per 100,000 New York City population. Entries in parentheses are percentage White of total suicides by the indicated sex category.

Appendix B

SAMPLE INCIDENT REPORT

600A — (4-64100M)

Department of Correction — Intradepartmental Memorandum

#538

Date : December 1, 1969

From : Warden

To : Commissioner of Correction (Thru Channels)

Subject: SUICIDE OF INMATE

1. On November 16, 1969 at approximately 3:20 a.m., inmate , was found hanging in his cell from a noose fashioned out of a belt which was affixed to the light fixture of his cell. The result of our investigation of the above incident is as follows.

2. On November 15, 1969, inmate was received at this institution accompanied by four (4) other inmates from Part 3 Bronx Court, at approximately 9:20 p.m. He was searched in the Receiving Room by Correction Officer , . According to the record, no contraband was found on his person. He was examined by Dr. , in the Receiving Room sometime between the hours of 9:40 p.m. and 10:20 p.m. The doctor noted on the Medical Card the following.

General Condition	Good
Signs of illness	Claims heart condition, murmur
Signs of trauma	None
Diagnosis	Heart condition, murmur
Drug user	Yes
Drug user	Heroin (stopped 2 months ago)

The reports of Officer and Dr. fail to note anything unusual in regard to the appearance or behavior of inmate while in the Receiving Room. The inmate, being a newly admitted drug addict, was assigned to the special observation section of Cell Block #2 (Section D) by Correction Officer . When it was learned that only one vacancy existed in that area and that it would be necessary to house with a homicide case who was already in the cell, it was decided by C.O. to lodge inmate in the "C" Section of the cell block on Tier 1B where adolescent trial inmates under punitive segregation are housed. It should be noted that although Officer assigned to the block and to the cell contrary to Departmental and Institutional Rules which require such assignments to be made by a Superior Officer, the block and cell assignments were correct since the area to which was assigned in cell block #2 was the official one designated to receive any overflow from the special observation section for newly admitted drug addicts.

3. Inmate was received by Correction Officer who was assigned to Post "C" of Cell Block #2, a special observation area as mentioned above designated to house the excess punitive segregation cases that would normally be housed in Cell Block 1B. According to the cell block "in and Out" sheets, was received at 11 p.m. According to the report submitted by Officer and the interrogation of him by the Warden in the presence of Deputy Warden , Officer claims that he strip-searched inmate when he received him as a new admission in accordance with institution procedure. However, he admits overlooking shoelaces and did not take them from him, as required by Institutional Order #38 of 1969. claims that definitely did not have a belt at the time that he searched him. He further stated that he put inmate in Cell #11 of Tier 1B because there was one vacancy in it.

At the time that was admitted to the cell its other occupant, Inmate , was at the Infirmary for medical examination. Earlier in the evening he had a fight with an inmate in Cell Block #5. As a result he was transferred to the punitive Segregation Section of Cell Block #2. When the doctor was available he was sent to the Infirmary. At approximately 12:30 a.m. inmate returned and was put in the cell with . Officer reports that for the balance of his tour, nothing unusual occurred which is substantiated both by his Watch Sheets and the Post Log Book.

4.(a) Officer was relieved at 12 mid-night by Correction Officer who assumed responsibility for Post C of Cell Block #2. According to the report of Officer and the verbal interrogation of him by the Warden and Deputy Warden on November 16, 1969, he made half hourly tour of inspections of the tiers under his jurisdiction as per Institutional and Departmental Regulations. Nothing unusual occurred on his post until approximately 1:30 a.m., November 16, 1969 when he heard loud noises and saw smoke coming from Tier 1B Cell #11. According to , when he arrived at the cell, he found inmates and struggling with a blanket and stamping on it. opened the cell and found that the fire was out. He ordered the occupants out of the cell and searched them, on the tier, to ascertain whether they had matches or cigarettes. In addition, he searched the cell & found some burned paper in the toilet. According to , the search proved negative and he then put them back into the cell and locked the gate. states that neither or had belts when he searched them. Officer admits that he did not summon another officer to be present when he opened and cell which was a clear violation of Departmental Rule #4.81, which requires two officers to be present when a cell is opened after lock-in. In addition, Correction Officer admits that he failed to report the incident to his superior. made a small entry on the line next to the time entry of 1:30 a.m. in the "C" Post of Cell Block #2's Log Book which states as follows. "1B11 fire in cell took care of same". The aforementioned entry is suspicious since it was evidently squeezed in after regular entry on the line and could have been made after the suicide occurred.

4.(b) further reports that at 3:20 a.m. he made a routine inspection of the three tiers and their occupants under his supervision by starting with Tier 1B, then Tier 2B and finishing with Tier 3B. He stated that just as he returned to his point of origin and had completed his entry in the Post Log Book at 3:20 a.m., he heard a strange noise coming from one of the cells on the flats. He ran to the source of the sound and found inmate in Cell 1B11 hanging from the cell light fixture by a noose made of a belt. quickly cut the belt, called for help and held up until Officer assigned to Post "D" of Cell Block #2, responded and opened the cell whereupon Officer entered. Since the inmate was unconscious, alleges that he immediately began artificial respiration and when that did not revive the inmate he gave mouth to mouth resusicitation. In the meantime, Captain , had been notified. Captain responded and summoned Institution Physician, , the only physician on duty, who responded promptly from the Infirmary. The doctor examined and promptly pronounced him dead at 3:35 a.m. The cell and person of the deceased was thoroughly searched for any evidence that would throw light on the incident, but none was found. The belt used as a noose by was light brown in color, was quite worn, and was apparently size 28 or 30.

5. The Tour Commander, Assistant Deputy Warden , was notified and arrived shortly after Captain and before the doctor. He states that when he arrived at the cell, C.O. was bending over inmate who was on the floor of the cell attempting to revive him. According to Kosnitsky, inmate was on the bottom bed apparently asleep. A/D/W notified the Warden, all required Department personnel and official agencies in full accordance with Departmental procedure.

6. Dr. reports that when he arrived at the scene, inmate was on the floor of his cell. Examination revealed, "no breath, no pulse, no heart sounds, lips cynote, little coagulated blood from nose. Deep strangulated ring on neck". As stated above, Dr. pronounced dead at 3:35 a.m.

7. The Warden arrived at 4:45 a.m. followed shortly afterwards by Deputy Warden . They took charge of the investigation and personally interrogated the following personnel and inmates.

Officer who discovered suicide.
4-12 Tour Officer in charge of the tier.
4-12 Tour Receiving Room Officer.
4-12 Tour "A" Post Cell Block #2
First Superior Officer to arrive on the scene.
Tour Commander
Attending Physician.
Deceased cell mate.
Occupant of cell #12 (next to decease's cell).
Occupant of Cell #10 (next to decease's cell).
Occupant of Cell #13
Occupant of Cell #12 (next to decease's cell).
Occupant of Cell #13
Occupant of Cell #10 (next to decease's cell).
Occupant of Cell #9

(a) Inmates and who occupied Cells #10 and 12 on both sides of the cell where the suicide occurred, state that before the suicide occurred they both heard inmates and fighting. They both state that the officer (both gave good discriptions of C.O.) came to the cell and opened it, took both inmates out on the tier (where and could see them) and slapped each.

(b) Inmate also stated that he thought inmates and were fighting in the cell.

(c) All of the other inmates interrogated claim that they were asleep during the incident.

(d) According to inmate , he first saw inmate when he returned from the Infirmary at 12:30 a.m. and found him in the cell. claims he did not speak to at that time, and went directly to bed. About ten or fifteen minutes after his arrival, one of blankets caught fire from the sparks that fell on it from a cigarette that was smoking in the bed. According to , both he and stamped on the blanket in order to put the fire out. The noise that resulted brought the officer who opened the cell and took both he and out of the cell and scolded them. was emphatic in denying that neither he or was slapped by C.O. who was the sole officer present at the time. However, he states that pushed them and at one point grabbed by the throat. According to , he went back to sleep and did not awaken until after came to the cell and found hanging. He states that he was deeply shocked by the sight and remained in the bed until the body was removed. According to , inmate gave no prior indication of suicide. He also denied that he had a fight with .

(e) C.O. , who was one of two officers assigned to the Receiving Room during the period that was processed, reports that there were a total of 44 inmates received during the period and that he noticed nothing unusual regarding any of them. He states that he assigned to the "D" Section of Cell Block #2 as a newly admitted drug addict. However, he did not assign him to a cell.

(f) Correction Officer , reports that on the 4-12 Tour November 15, 1969, he was assigned to the "A" Post of Cell Block #2 and that he received approximately seven (7) inmates from the Receiving Room who were classified as N.A.D.C. cases. He checked with Correction Officer who had the "D" Post of Cell Block #2, where the N.A.D.C. cases were housed and it was found that they only had room for six (6) of these inmates. Officer put inmate into Cell 1B-11 as a temporary assignment until room could be made in the "D" Section of Block #2. Officer , who had the "C" Post of Cell Block #2 searched the inmate and made up a Watch Sheet before locking the inmate in.

(g) Correction Officer , who was assigned to the "D" Post of Cell Block #2 on November 16, 1969 reports that he has no knowledge of the incident except as follows. called to him, at approximately 3:20 a.m. to open Cell 1B-11. ran to the operating mechanism and opened the cell and then ran to Cell #11 where he found supporting an inmate through the bars. put the inmate on the floor and began artificial respiration.

8. Subsequent investigation, conducted on November 17 through November 19, 1969, produced the following.

(a) Correction Officer , the other Correction Officer assigned to the Receiving Room on the 4-12 Tour of November 15, 1969, during the time that was processed, states that he searched and that he does not remember if he was wearing a belt. He noticed nothing particular about inmate .

(b) Captain , on duty on the 4-12 Tour of November 15, 1969 was assigned to supervise the Control Room, Cell Blocks 1A and 1B, the General Office and the General Office and the Receiving Room, reports that he made several trips to the Receiving Room during his tour and noticed nothing out of the ordinary. According to Departmental Rules, it was the responsibility of the Receiving Room Captain to assign all new admissions to their housing locations. When questioned as to whether he had made such assignments, Captain stated that he could not remember. However, no entries were made on Departmental Form #71, Cell Location Card, indicating by whose authority was assigned to Cell 1B-11 of Cell Block #2. Captain 's apparent dereliction of duty in not assigning new admissions to housing locations on November 15, 1969 will be the subject of subsequent disciplinary action against him.

9. On November 16, 1969 the Medical Examiner, Dr. , came to the institution, examined the body of the deceased and directed it be moved to the Medical Examiner's office in Manhattan. This was done. As per the Medical Examiner's request, the belt used by to commit suicide was turned over to him. The belt was light brown, size 28 or 30 and apparently quite worn.

10. On November 17, 1969 Assistant District Attorney informed us that he had assumed responsibility for the case. On November 19, 1969 Detectives and of the Bronx District Attorney's office and A/D/A came to the institution and conducted an investigation during which they interrogated all personnel and inmates having knowledge of the incident that were present in the institution. In addition, they were furnished with copies of all reports regarding the incident in our possession. Subsequent conversations with A/D/A reveals that the suicide of will be submitted to the Grand Jury during the week of December 9, 1969.

11. (a) Inmate , of Haven Plaza, Manhattan. He is 17 years of age. He was admitted to Manhattan House of Detention on November 13, 1969 from Criminal Court Manhattan Part 1A-2 charges with violation of Sections 165.25 (jostling) and 240.35 (loitering) of the Penal Law. He is being held under $500.00 bond or $100.00 cash bail. He was admitted to this institution on November 14, 1969 and discharged on cash bail November 16, 1969.

(b) Inmate , of , 17 years of age. He was admitted to this institution on November 15, 1969 from Criminal Court Bronx Part 3, charged with violation of Sections 140.20 (burglary 3 degree) and 165.45 (criminal possession of dangerous drug 2 degree) of the Penal Law. He was being held under $500.00 bail for examination November 18, 1969 in Criminal Court Bronx.

12. Findings:

(a) That on November 16, 1969 at approximately 3:35 a.m. inmate , committed suicide by hanging in his cell.

(b) That the suicide was accomplished by fashioning a noose out of a belt one end of which was affixed to the light fixture of his cell and the other around his neck.

(c) That gave no previous indication that he intended to commit suicide, either verbally or by his actions.

(d) That inmate , as a newly admitted drug addict, was properly placed under special observation and housed in the Punitive Segregation Section of Cell Block #2 due to the fact that the regular section of Cell Block #2, designed for newly admitted drug addicts, was filled up.

(e) That although was properly housed, it was accomplished without the authorization of Captain , who was in charge of the Receiving Room at that time.

(f) That C.O. , the officer assigned to the "C" Post of Cell Block #2 where was housed, failed to properly search the inmate which is evidenced by his failure to remove 's shoelaces which were still in his shoes after the suicide. This was a violation of Institutional Order #38 of 1969.

(g) That the investigation of 's suicide revealed that at approximately 1:30 a.m. November 16, 1969 Correction Officer opened Cell 1B11, occupied at the time by inmates and and took both inmates out of the cell to allegedly search them after a fire had been discovered in the cell. failed to obey Departmental Rule #4.81 which requires two to be present when a cell is opened after lock-in at mid-night. In addition, Correction Officer did not report the fire to his superiors nor did he file an infraction of institution rules against either inmate.

(h) That inmates , and , both allege that C.O. slapped both inmate and inmate

when he removed them from their cell at 1:30 a.m. November 16, 1969. However, inmate states that he was not slapped.

(i) That the investigation of the suicide of inmate has been turned over to the Bronx District Attorney's office and that the case will be presented to the Grand Jury.

(j) That the investigation indicates a need for additional direct custodial supervision for both housing areas and the Receiving Room.

(k) That additional housing space, preferably of the dormitory type, is urgently needed for newly admitted drug addicts.

13. Recommendations:

(a) That disciplinary charges be preferred against Captain , for violation of Departmental Rule #4.14-h (3) in that on November 15, 1969 while in charge of the Institution Receiving Room he did not make housing assignments of new admissions to the institution. (This will be accomplished).

(b) That disciplinary charges be preferred against Correction Officer , for violation of Institutional Order #38 of 1969 in that while assigned to the "C" Post of Cell Block #2, he failed to properly search inmate who was a new admission which is evidenced by his failure to remove 's shoelaces which were found in his shoes after his suicide. (This will be accomplished).

(c) That disciplinary charges be preferred against Correction Officer , for violation of Departmental Rule #5.90 in that he failed to report that a fire had occurred in Cell 1B11 occupied by inmates and on November 16, 1969 at approximately 1:30 a.m. (This will be accomplished).

(d) That disciplinary charges be preferred against Correction Officer , for violation of Departmental Rule #4.81 in that he failed to have another officer present when he opened Cell 1B11 occupied by inmates and on November 16, 1969 at approximately 1:30 a.m. (This will be accomplished).

(e) That additional custodial supervisory positions be assigned to the institution as soon as practical, as per the Institution's 1970-1971 budget requests to provide more direct supervision of custodial subordinates.

(f) That additional and a better type of housing are urgently needed for the institution's newly admitted drug addicts under special observation. (This is being accomplished and should be ready for occupancy by December 8, 1969).

168 (9-70)

THE CITY OF NEW YORK
DEPARTMENT OF CORRECTION

November 17, 1969
Date

From: Director of Operations

To: (See Distribution Below)

Subject: REPORT OF UNUSUAL OCCURRENCE AT _____

1. The following incident which occurred at Block 2 - Cell LB11

was reported to this office this date at 11:10 A.M. ~~P.M.~~

2. The pertinent details are as follows:

INCIDENT: Suicide

DATE: November 16, 1969 TIME: 3:20 A.M. ~~P.M.~~

INMATE (S) INVOLVED: (Insert name, number, age, home address, date received, court, court status, charge, length of sentence and tentative release date for each inmate listed)

- 17 yrs. - DAT - Bronx, NY - Recd.

11-15-69 from Bronx County Crim. Ct. Pt. 3 on chgs. of burglary and criminal possession -
Held under $5,000 bail for examination 11-18-69

CIRCUMSTANCES AS REPORTED (Who, What, When, Where, How and Why)

At about 3:20 a.m., November 16, 1969, Correction Officer , assigned to block 2, upon investigating choking sounds coming from cell LB11 in the punitive segregation section of the block, observed inmate , housed in said cell, hanging with a noose fashioned from a belt around his neck and tied to the cell light fixture. Officer reached through the bars of the cell, cut the noose and notified Assistant Deputy Warden who responded with Dr. . Dr supervised resuscitation efforts. Inmate was pronounced dead at about 3:35 a.m., November 16, 1969.

Inmate who was housed in the same cell with inmate stated that he was asleep and did not hear anything unusual at the time of the incident. Inmate was housed under special observation in the punitive segregation section of the block because of a lack of space in the special observation section for newly admitted drug addicts.

An examination of institutional records indicates that inmate was received from court as a new case at 9:00 p.m., November 15, 1969. Medical examination upon admission by Dr. showed that inmate was in good physical condition with no signs of trauma. However, inmate claimed a heart murmur.

Correction Officer reported that at about 1:30 a.m. he helped inmates and put out a fire in their cell, such fire caused by a lighted cigarette falling on a blanket.

PERSONNEL INVOLVED: A/D/W Correction Officer

REPORTED BY: _____ A/D/W
Name Title

Authorized by Warden to transmit report

AGENCIES NOTIFIED: (Insert time, date, agency and person notified)

11-16-69 - 4:10 a.m. Harbor Pct.
~~11-16-69 - 4:25 a.m. Harbor Pct. Ptl.~~
11-16-69 - 4:45 a.m. District Attorney -
~~11-16-69 - 5:45 a.m. Medical Examiner's Office~~

Distribution: Commissioner
Assistant Commissioner (Administration)
Assistant Commissioner (Rehabilitation)
Legal Division
Director of Operations
Director of Psychiatry
Medical Director

12/3/69-Written report received from inst.
12/5/69-Transmitted to Legal Division

_____
Director of Operations

CIRCUMSTANCES AS REPORTED (Who, What, When, Where, How and Why)

According to Correction Office , he searched the cell at the time and did not notice any belt. Inmate did not make any complaints when questioned by the officer about the fire in the cell. However, officer did not report the fire incident to any one until questioned about the suicide.

At the time of this report it could not be determined how the belt was obtained by inmate .

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